A. Type of Handbook

Part P, Division I, is the provider-specific Medicaid handbook for occupational therapy (OT) services. Part P, Division I, includes information for providers on provider eligibility criteria, recipient eligibility, covered services, payment method, and billing instructions. Use this handbook in conjunction with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for general policy and regulation information for AFDC/Healthy Start recipients enrolled in a Medicaid Health Maintenance Organization (HMO).

B. Provider Information

Provider Eligibility and Certification

Certification Requirements for Occupational Therapists

For Medicaid certification, occupational therapists (OTs) must:

- Be certified by the National Board for Certification in Occupational Therapy, Inc. (NBCOT) as a registered OT.
- Have graduated from an OT program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) and have completed the required field work experience.

National certification is valid until eight weeks after the NBCOT examination is taken. After passing the examination, the OT is certified by the NBCOT in the calendar year the examination is taken.

Certification Requirements for Occupational Therapy Assistants

For Medicaid certification, occupational therapy assistants (OTAs):

- Must be certified by the NBCOT.
- Must provide services under the direct, immediate, on-site supervision of a Medicaid-certified OT, except when:
  - ➔ The OTA is performing services for the purpose of providing activities of daily living skills.
  - ➔ The OTA's supervisor visits the recipient bi-weekly or after every five visits by the OTA to the recipient.
  - ➔ The OTA's supervisor meets to discuss the recipient's treatment after every five contacts between the OTA and the recipient.
- May not bill or be reimbursed directly for their services, and must submit the "Declaration of Supervision and Authorization to Pay" agreement.

All OTAs (other than OTAs providing services *exclusively* for a rehabilitation agency, school-based services (SBS) provider, or *at a licensed hospital location*) must be individually certified.

B. Provider Information (continued)

Wisconsin Medicaid issues the provider number to an OTA *only* as the performing provider number on all submitted claims, and it may *not* be used as a billing provider number.

Note: Claims for services (other than rehabilitation agency, SBS, or at the licensed hospital location) must be billed with a group billing number or the certified OTA supervisor's provider number. The OTA's non-billing performing provider number must be included as the performer.

Therapy assistants may not be independent providers due to Medicaid supervision requirements.

When OTAs change their employer, supervising certified OT, or work address, they must complete a new "Declaration of Supervision and Authorization to Pay" agreement. Refer to Appendix 14 of this handbook for a blank, reproducible "Declaration of Supervision and Authorization to Pay" agreement. Refer to Appendix 34 of Part A, the all-provider handbook, for a blank, reproducible "Wisconsin Medicaid Change of Address or Status" form.

Occupational Therapy Aides

Wisconsin Medicaid does not certify OT aides or cover their services under the Medicaid OT benefit.

Certification Requirements for Rehabilitation Agencies

Rehabilitation agencies must meet a number of requirements which do not apply to independent therapists.

Rehabilitation agencies must meet the criteria in HFS 105.34, Wis. Admin. Code:
"For Medicaid certification, a rehabilitation agency providing outpatient physical therapy (PT), or speech-language pathology, or OT will be certified to participate in *Medicare* as an outpatient rehabilitation agency under 42 Code of Federal Regulations (CFR) 485.701 through 485.729, formerly 42 CFR 405.1702 to 405.1726."

Under 42 CFR, Part 485, Subpart H, a rehabilitation agency provides an integrated multidisciplinary program of services to upgrade the physical functioning of handicapped, disabled individuals. To accomplish this, the agency brings together a team of specialized rehabilitation personnel to provide at least one of the following services:

- OT, PT, speech-language pathology, or rehabilitation program services.
- Social or vocational adjustment services.

The Wisconsin Department of Health and Family Services (DHFS), Division of Health, Bureau of Quality Assurance surveys a rehabilitation agency before the agency receives Medicare certification. The DHFS issues the survey under a contract with the federal Health Care Financing Administration (HCFA). The survey reviews the agency's administration and rehabilitation programs.

B. Provider Information (continued)

For information about Medicare certification, please contact:

Bureau of Quality Assurance
Division of Supportive Living
PO Box 7851
Madison WI 53707-7851

OTs and OTAs employed by, or under contract to, rehabilitation agencies must meet all of the requirements for Medicaid certification. The rehabilitation agency must maintain records showing that they meet these requirements. However, OTs employed by, or under contract to, rehabilitation agencies are not required to be individually certified by Wisconsin Medicaid when providing services that will be billed under the rehabilitation agency billing number.

Medicaid Certification Process for Rehabilitation Agencies

Providers should apply simultaneously to Medicare and Wisconsin Medicaid for certification as a rehabilitation agency to ensure the effective certification dates coincide. Wisconsin Medicaid must verify the Medicare certification number before a Medicaid provider number is issued. Medicaid therapy group providers considering conversion to the Medicaid rehabilitation agency provider type are advised to contact the fiscal agent, EDS, for more information about the conversion process and to ensure services are billed appropriately during the conversion process. Refer to Appendix 2 of Part A, the all-provider handbook, for the fiscal agent Provider Maintenance telephone number and mailing address.

Certification for Durable Medical Equipment

Certified OTs and rehabilitation agencies do not need separate certification as a durable medical equipment (DME) provider to provide the equipment identified in the DME Index as billable by OT providers or by those therapy groups and rehabilitation agencies which include OT. Separate DME certification is required to provide DME that are not identified as billable by these therapy provider types.

Part N, the DME provider handbook, and *Wisconsin Medicaid Updates* contain all DME policy and billing instructions for OT providers, those therapy groups and rehabilitation agencies which include OT, and DME providers. All therapy providers receive a copy of Part N. For additional copies of the Part N provider handbook, complete the form in Appendix 35 of Part A, the all-provider handbook.

Types of Medicaid Provider Certification and Billing Numbers Issued to Individuals and Organizations Providing Occupational Therapy Services

Individual Performing Provider Number That Is Also a Billing Number

The following applies for an OT who practices independently:

- The OT may independently provide services, bill Wisconsin Medicaid directly, and request prior authorization (PA) for the OT services provided to Medicaid recipients.

B. Provider Information (continued)

- The OT may bill and request PA for the services of assistants under the certified OT's supervision.
- The OT's Medicaid provider number may be used as a billing number or a performing number.

OTs eligible for Medicaid certification as individual performing providers with their own billing numbers are:

- OTs in independent practice.
- OTs working under contract/arrangements with a nursing home where the OT acts as an individual performing provider (the nursing home's provider number must be used to bill Wisconsin Medicaid and request PA if the claims are to be paid to the nursing home).
- OTs working for an organization that is required to indicate the performer's number on the claim (the OT's number is used as the performing provider number if a group billing number is used [refer to the next section]).

Individual Performing Provider Number That Is Not a Billing Number

The following applies for an OTA working under the immediate on-site supervision of a Medicaid-certified OT:

- The OT allows the OTA to provide services to Medicaid recipients. Those services are then billed to Wisconsin Medicaid using the provider number of the OTA's supervisor or clinic along with the OTA's number as the performing provider number.

The individual OTAs included are the following:

- OTAs supervised by a Medicaid-certified OT in independent practice.
- OTAs supervised by a Medicaid-certified OT in an organization required to include the performing provider's number on the claim.

Group Billing Number That Requires a Separate Performing Provider Number

A group billing number is generally issued as an accounting or billing convenience for groups of individually certified providers. The group billing number allows the group of individuals to do all of the following:

- Bill Wisconsin Medicaid.
- Receive one payment for each claims processing cycle.
- Request PA under the group billing number.

B. Provider Information (continued)

Examples of groups with individually certified providers include the following:

- *Therapy groups* - Provide two or more types of therapy (e.g., PT and OT, or PT, OT, and Speech).
- *Therapy clinics* - Provide one type of therapy only (e.g., PT or OT).
- *Nursing home* - OT services provided by OT staff employed by the nursing home, or under contract between the nursing home and individually certified OTs; the nursing home's provider number is used as the billing number.
- *Licensed hospital's off-site services* - Hospital OT staff providing OT services off the licensed hospital location. Services cannot be billed as hospital outpatient; they must be billed fee-for-service and include the performing provider number. The licensed hospital location is the physical entity surveyed and licensed by the Wisconsin Bureau of Quality Assurance under Chapter 50, Wis. Stats. Off-site services include services at satellite offices, nursing homes, private homes, and sheltered workshops.

Group Billing Number, Performing Provider Number Is Not Required

Certain organizations employing OT staff who meet the Medicaid individual certification requirements do not require a separate Medicaid performing provider number:

- The organization may bill Wisconsin Medicaid, receive one payment for each claims processing cycle, and request PA under one provider number.
- No separate Medicaid certification is required for individual performing providers. However, the Medicaid-certified organization must maintain records documenting that their OTs and OTAs meet Medicaid certification requirements for OTs and OTAs (excludes SBS providers).

Examples of organizations employing OT staff who are not required to obtain a separate Medicaid performing provider number include the following:

- Rehabilitation agencies.
- Licensed hospitals (only for services provided at the licensed hospital site; individual certification of staff is required for services provided off the licensed hospital site and claims require the performer's provider number).
- Home health agencies with OTs providing therapy services.

For school districts and Cooperative Educational Service Agencies (CESAs) certified as SBS providers, therapy services provided at school must be billed with an SBS provider number. SBS staff must meet Department of Public Instruction (DPI) certification and licensure requirements.

B. Provider Information (continued)

Payment Methods

OT and rehabilitation agency services under HFS 107.17, Wis. Admin. Code, are paid the lesser of:

- The provider's usual and customary charge.
- The maximum allowable fee.

The Medicaid maximum allowable fee applies to one treatment unit which coincides with the specific *Current Procedural Terminology* (CPT) procedure code. Payment for treatment less than the CPT procedure code unit per session is prorated. Additional units are paid only when a full unit of service is actually provided. Refer to Appendix 4 of this handbook for specific procedure codes and to Appendix 5 of this handbook for treatment units.

Overhead Costs

Payment for direct and associated overhead costs, including facility overhead costs, is included in the payment for each treatment unit.

Provider Responsibilities

Specific responsibilities as a certified provider are stated in Section IV of Part A, the all-provider handbook. Refer to Section IV of Part A, the all-provider handbook, for information about:

- Fair treatment of the recipient.
- Maintenance of records.
- Recipient requests for noncovered services.
- Grounds for provider sanctions.
- Services rendered to a recipient during periods of retroactive eligibility.
- Additional state and federal requirements.

C. Recipient Information

Verifying Recipient Eligibility

Wisconsin Medicaid providers should check the recipient's identification card *before* providing service to determine recipient eligibility and any limitations to his/her coverage.

Eligible recipients receive identification cards monthly that are valid through the end of the month issued. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and, when applicable, an indicator of health insurance, HMO, and Medicare coverage.

C. Recipient Information (continued)

Refer to Section V of Part A, the all-provider handbook, for detailed information about eligibility for Wisconsin Medicaid, identification cards, temporary cards, restricted cards, and eligibility verification. *Review* Section V of Part A, the all-provider handbook, *before* rendering services. A sample identification card is in Appendix 7 of Part A, the all-provider handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining OT services. Refer to Appendix 4 of this handbook for procedure codes and their applicable copayment.

Copayment exemptions include:

- Emergency services.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.
- Services provided to a pregnant woman if the services are pregnancy-related.
- Services covered by Medicaid-contracted managed care programs to enrollees of the managed care program.
- Family planning services and related supplies.

All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the recipient. Providers shall not, at their discretion, waive the recipient copayment requirement, unless the provider determines that the cost of collecting the payment, coinsurance, or deductible exceeds the amount to be collected. However, providers may not deny services to a recipient for failing to make a copayment.

Wisconsin Medicaid automatically deducts applicable copayment amounts from Medicaid payments. Do not reduce the billed amount of the claim by the amount of recipient copayment.

Annual Copayment Maximum

No copayment is deducted after the first 30 hours or $1,500 of services per calendar year, per recipient, regardless of OT provider.

Wisconsin Medicaid calculates copayment upper limits separately for PT, OT, and speech-language pathology, per recipient, per calendar year.

Recipients Enrolled in Managed Care Programs

Providers must check the recipient's current identification card for managed care program

C. Recipient Information (continued)

coverage before providing services. Recipients enrolled in Medicaid-contracted managed care programs receive a yellow identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. Refer to Chapter 4 in the Wisconsin Medicaid Managed Care Guide's provider section for the HMO Medicaid ID codes.

Wisconsin Medicaid denies claims submitted to the fiscal agent for services covered by Medicaid-contracted managed care programs. OT claims must be submitted to the managed care program if the recipient is enrolled in a managed care program.

For recipients enrolled in a Medicaid-contracted managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and PA for OT services.

Managed care programs exclude PT, OT, and speech therapy provided in the school from coverage under their program. Refer to Appendix 22 of Part A, the all-provider handbook, for more information.

Refer to the Wisconsin Medicaid Managed Care Guide's provider section for additional information about noncovered services, emergency services, and hospitalizations.

D. HealthCheck

HealthCheck is Wisconsin Medicaid's federally mandated childhood preventive health program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). HealthCheck consists of a comprehensive screening of eligible recipients under the age of 21 which includes:

- Review of growth and development.
- Identification of potential physical or developmental problems.
- Preventive health education.
- Referral assistance to appropriate providers of service.

HealthCheck also includes targeted outreach and case management services to "at-risk" children to ensure that these children have access to needed medical, social, and educational services.

Wisconsin Medicaid covers medically necessary OT services under the OT benefit. HealthCheck benefit services also must be medically necessary. A request for PA for OT services that is denied for lack of medical necessity under the OT benefit generally is not approved under the HealthCheck benefit. Both benefits use the same PA criteria and requirements to determine medical necessity.

HealthCheck "Other Services"

Wisconsin Medicaid considers requests for medically necessary OT services (under the HealthCheck benefit) which are not specifically listed as covered services when the following conditions are met:

D. HealthCheck (continued)

- The service requested is for an individual under 21 years of age.
- The service is medically necessary to correct or improve a condition or defect discovered during a HealthCheck/EPSDT screening.
- The service is one which is an allowable service under federal regulations.

All such services require PA for payment. Refer to Section III of this handbook for PA information.

Refer to Section IV of Part A, the all-provider handbook, for additional information on HealthCheck "Other Services."

E. School-Based Services Benefit

Background

Under HFS 107.36, Wis. Admin. Code (the SBS benefit), Wisconsin Medicaid reimburses school districts and CESAs for medically related services that are included in a child's Individualized Education Program (IEP). Wisconsin Medicaid covers SBS provided to Medicaid-eligible children under age 21, or for any school term during which the individual became 21 years old. Wisconsin Medicaid uses the IEP to establish medical necessity for health-related SBS services. See HFS 105.53 and HFS 107.36, Wis. Admin. Code, for Medicaid provider certification, coverage, limitations, and requirements under the SBS benefit.

Covered School-Based Services

The following medically related face-to-face services are covered under the SBS benefit when they are identified in the child's IEP and certain requirements are met:

1. PT.
2. OT.
3. Speech-language pathology.
4. Audiology and hearing.
5. Nursing.
6. Psychological services, counseling, and social work.
7. Developmental testing and assessments when they result in an IEP.
8. Transportation.
9. DME.

Certification for School-Based Services: Impact on Therapy Providers

Services covered under the SBS benefit that are delivered at a school site must be billed under the school district's or CESA's SBS provider number. This includes services delivered by school and non-school employees who are under contract or arrangement with the school district to deliver services at the school site.

E. School-Based Services Benefit (continued)

Services under the SBS benefit that are delivered at a school site may not be billed by individuals or groups with the following Medicaid certification that duplicates SBS certification without a waiver from Wisconsin Medicaid:

- PT and physical therapy assistants (PTAs).
- Rehabilitation agencies.
- Therapy groups.
- OT and OTAs.
- Speech and hearing clinics.
- Audiologists.
- Speech-language pathologists/therapists.
- Transportation.
- Nurse practitioners.

Starting July 1, 1996, individual providers may not be certified for the above duplicate service areas when a school, school district, or CESA is the provider's payee. School districts and CESAs are not eligible for new group certification for the above provider groups beginning July 1, 1996.

F. Birth to 3 Program

The Birth to 3 program under the federal Individuals with Disabilities Education Act (IDEA) Part C (formerly Part H) entitles eligible children to certain services to enhance their development, minimize potential for further delay, and enhance the capacity of families to meet the special needs of these children. Eligible children are those ages 0-36 months with developmental disabilities or delays. Under Part C, services must be delivered in a "natural environment," such as the child's home and other community settings where children without disabilities participate.

Birth to 3 (early intervention) services are administered by counties, usually departments of community programs or human services departments. Birth to 3 services may include:

- Evaluation and assessment.
- Special instruction.
- OT.
- PT.
- Speech-language pathology.
- Audiology.

F. Birth to 3 Program (continued)

- Psychological.
- Social work.
- Vision.
- Assistive technology.
- Transportation.
- Service coordination.
- Medical services for diagnostic and evaluation purposes.
- Health services to enable the child to benefit from other early intervention services.
- Family training, counseling, and home visits.

Children determined to be eligible for Birth to 3 services receive an Individual Family Services Plan (IFSP) following a comprehensive family-directed assessment, to develop individualized outcomes for the child's development and determine the necessary early intervention services.

When a Birth to 3 agency is involved with a child (either for eligibility determination or service delivery), Wisconsin Medicaid therapy providers must coordinate both therapy evaluations and service delivery with the Birth to 3 agency. Wisconsin Medicaid therapy providers must refer children to the county Birth to 3 agency who may meet Birth to 3 eligibility criteria and benefit from Birth to 3 services.

Federal regulations require that IDEA funds are the payer of last resort after all other private and public funds, including Medicaid. This means that for children in the Birth to 3 program, Wisconsin Medicaid providers bill Wisconsin Medicaid before billing the county Birth to 3 program for services, while continuing to cooperate and coordinate with the county Birth to 3 agency as described above.

Note that SBS providers may not bill for Birth to 3 services.